

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Maurice M. Henowitz, N.H.A.
65 Heather Road
Hamden, CT 06518

Petition No. 960813-036-002

FINAL DECISION

Procedural Background

On February 19, 1998, the Department of Public Health ("the Department") issued a Statement of Complaint ("the Charges") against Maurice M. Henowitz, N.H.A. ("respondent"). Dept. Exh. 2. The Charges sought disciplinary action pursuant to Connecticut General Statutes §§19a-17 and 517, regarding respondent's Connecticut nursing home administrator license.

On February 26, 1998, the Commissioner of the Department appointed this Hearing Officer to hear this case and to determine findings of fact and conclusions of law, and to issue an Order. Dept. Exh. 1.

On March 10, 1998, respondent filed an Answer to the Charges. Resp. Exh. A.

A hearing on this matter was initially scheduled for May 5, 1998. On April 16, 1998, the Department requested a continuance. Without objection, the request was granted, and the hearing was continued until July 14, 1998. On June 22, 1998, respondent requested a continuance. Without objection, the request was granted, and the hearing was continued. Dept. Exh. 1.

On August 13 and 14, and September 24 and 25, 1998, an administrative hearing was held in accordance with Connecticut General Statutes Chapter 54 and §19a-9-1, *et seq.* of the Regulations of Connecticut State Agencies ("the Regulations"). Respondent appeared and was represented by Laura Lee Dorflinger, Esq.; Gareth Bye, Esq., represented the Department. Both the Department and respondent presented evidence and conducted cross-examination of witnesses.

This Final Decision is based entirely on the record and sets forth this Hearing Officer's findings of fact, conclusions of law, and order.

Allegations and Answer

In paragraph 1 of the Charges, the Department alleges that respondent has been at all times referenced in the Charges the holder of Connecticut nursing home administrator license number 001300. Dept. Exh. 2. Respondent admits this allegation. Resp. Exh. A..

In paragraph 2 of the Charges, the Department alleges that at all relevant times, respondent was employed as a nursing home administrator at Barnett Multi-Health Care Center (hereinafter "Barnett"), a nursing home located in Bridgeport, Connecticut, and licensed by the Department under Chapter 368v of the General Statutes of Connecticut. Dept. Exh. 2. Respondent admits this allegation. Resp. Exh. A.

With Regard to Count One

The Department alleges that on or about April 1996 through and including August 1996, while working as facility administrator, respondent failed in his duties to be responsible for the overall management and operation of Barnett, as evidenced by the following: (a) unannounced visits were conducted at Barnett on July 17, 18, 20, 21, 22, 23, 25, 29, and 30, 1996, by representatives of the Department's Division of Health Systems Regulation ("the inspectors") for the purpose of investigating multiple complaints. Inspections revealed that the facility had provided substandard quality of care which constituted immediate jeopardy to the health and safety of the residents at the facility; (b) respondent was not able to provide the Department with assurances that sufficient staffing would be available to ensure that residents received quality of care; (c) during the period of July 18 through 23, 1996, five residents with a history of a significant weight loss failed to receive Magnacal, a nutritional supplement, as per physician's orders, due to the supplement not being available in the facility; (d) on July 19, 1996, four residents with a history of a significant weight loss and/or with pressure sore development failed to receive Promod, a protein supplement, as per physician orders,

due to the supplement not being available in the facility; (e) on July 29, 1996, one patient, with a pressure sore failed to receive a treatment of Zeasorb-AF powder, as per physician orders, due to the medication not being available in the facility; (f) on July 20, 1996, two residents with Stage II sores had not been provided with pressure relieving devices on their beds due to none being available in the facility; (g) on July 20, 1996, residents who were incontinent of urine had not been provided with incontinent care three times a shift due to the facility not having enough linen; (h) respondent was unable to provide the Department with assurances that he could ensure the financial viability of the facility; and/or, (i) on August 5, 1996, the Superior Court for the Judicial District of Hartford/New Britain found that conditions existed at Barnett which required the appointment of a receiver as set forth in Connecticut General Statutes §19a-543(3) and (4).

The Department alleges that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §19a-517(b)(3) and (4), taken in conjunction with §19-13-D8t(f)(3)(A) of the Regulations. Dept. Exh. 2. Respondent denies all of these allegations except for allegation (i) which he leaves to the Department for its proof. Resp. Exh. A.

With Regard to Count Two

The Department alleges that on or about April 1996 through and including August 1996, respondent failed to serve as a liaison between the governing body, medical and nursing staff and other professionals and supervisory staff as evidenced by the following: (a) during the period of March 15, 1996, through July 23, 1996, quality assurance meetings had not been conducted on a monthly basis as per the facility policy; (b) respondent failed to implement a quality assurance plan as required by the facility protocol, to identify and/or resolve problems in the facility; (c) the administrator failed to identify or address the increase in pressure sores, from April of 1996 through July 23, 1996; (d) respondent failed to identify the problem of not having sufficient linens to meet the needs of the residents and/or the minimum requirements of the State of Connecticut Public Health Code;

(e) respondent failed to ensure that an intravenous therapy committee had been established as per facility protocol. Although facility policy directed that IV data would be reviewed monthly, a review of the facility's intravenous therapy program had not occurred since April of 1996; (f) respondent failed to ensure that an infection control program was established to prevent the development and transmission of infections in that: (i) seven residents with identified infections were not appropriately monitored; (ii) infection control policies had not been implemented; (iii) the infection control committee failed to meet on a quarterly basis; (iv) the infection control committee failed to direct the facility's response to infection and failed to identify corrective measures; and/or, (v) the facility failed to implement infection control policies relative to their intravenous therapy program.

The Department alleges that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §19a-517(b)(3) and (4), taken in conjunction with §19-13-D8t(f)(3)(A) of the Regulations. Dept. Exh. 2. Respondent denies all of these allegations. Resp. Exh. A.

With Regard to Count Three

The Department alleges that on or about April 1996 through and including August 1996, respondent failed to enforce all applicable local and state regulations as well as facility by-laws as evidenced by the following: (a) during visits conducted at Barnett on July 17, 18, 20, 21, 22, 23, 25, 29, and 30, 1996, it was found that numerous violations of the State of Connecticut Public Health Code and/or General Statutes of Connecticut and/or Title XVIII or XIX had provided substandard quality of care and constituted immediate jeopardy to the health and safety of the residents at the facility.

The Department alleges that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §19a-517(b)(3) and (4), taken in conjunction with §19-13-D8t(f)(3)(A) of the Regulations. Dept. Exh. 2. Respondent denies all of these allegations. Resp. Exh. A.

With Regard to Count Four

The Department alleges that during the period of April 1996 through and including August 1996, respondent failed to ensure that sufficient numbers of qualified personnel were employed to ensure that patient needs were assessed and met as evidenced by the following: (a) violations identified during the course of the visits relative to patient care revealed that an emergency situation existed at Barnett, which jeopardized the health, safety and welfare of the residents; (b) respondent was unable to provide the Department with assurances that quality of care could be provided to the residents; (c) on August 5, 1996, the Superior Court for the Judicial District of Hartford/New Britain found the conditions existed at Barnett which requires the appointment of a receiver as set forth in Connecticut General Statutes §19a-543(3) and (4).

The Department alleges that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes §19a-517(b)(c)(3) and (4), taken in conjunction with §19-13-D8t(f)(3)(A), (C), and (F) of the Regulations. Dept. Exh. 2. Respondent denies all of these allegations except for allegation (c) which he leaves to the Department for its proof. Resp. Exh. A.

Findings of Fact

1. Respondent has been at all times referenced in the Charges the holder of Connecticut nursing home administrator license number 001300. Dept. Exh. 2; Resp. Exh. A.
2. At all relevant times, respondent was employed as a nursing home administrator at Barnett, a nursing home located in Bridgeport, Connecticut, and licensed by the Department under Chapter 368v of the General Statutes of Connecticut. Dept. Exh. 2; Resp. Exh. A.
3. On April 18, 1996, respondent attended an office conference with other representatives of Barnett where Joan Leavitt, R.N., Health Services Supervisor for the Department, expressed the Department's concerns over Barnett's financial viability. Respondent was advised that as administrator of Barnett, he was responsible for the care of the residents. He was further advised that if the conditions at Barnett deteriorated, or residents were at risk, he should immediately

notify the Department, so that appropriate actions could be taken. Tr. 8/13/98, pp. 46-48; Dept. Exhs. 25 and 27.

4. On May 3, 1996, respondent represented in an Administrator's Certificate submitted to the Department that he agreed "to assume responsibility for [Barnett] in accordance with the Public Health Code of the State of Connecticut ("the Public Health Code") and all applicable Connecticut General Statutes." Dept. Exh. 14.
5. On numerous occasions between April and August of 1996, respondent represented himself to be the nursing home administrator of Barnett. Dept. Exhs. 6-7, 14, 23, 25, and 26; Resp. Exhs. O and U.
6. On July 17, 18, 20, 21, 22, 23, 25, 29, and 30, 1996, the inspectors conducted unannounced inspections at Barnett. The findings of the visits are documented in the Licensing Inspection Report dated August 1, 1998, and the Statement of Deficiencies and Plan of Correction executed by respondent on August 13, 1996. Dept. Exhs. 8 and 9.
7. Respondent does not challenge any of the Department's findings. Tr. 9/25/98, p. 112.
8. A state of immediate jeopardy exists when a facility is not in compliance with one or more federal regulations, and the non-compliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Dept. Exh. 10; Tr. 8/13/96, pp. 102-104.
9. During the inspections conducted between July 17 and 30, 1996, the Department determined that an immediate and serious threat to resident health and safety existed at Barnett due to the facility's inability to provide care or services essential to maintaining or improving residents' health. Dept. Exh. 8, p. 1.
10. During the inspections conducted between July 17 and 30, 1996, the Department determined that due to the deficiencies at Barnett, the facility was in a state of immediate jeopardy. Tr. 8/13/98, pp. 108 and 115-116; Dept. Exh 22.
11. As a consequence of the inspections conducted between July 17 and 30, 1996, on August 5, 1996, the Department requested and received an ex parte appointment of a receiver as provided for in §19a-543(3) and (4) of the Connecticut General Statutes. Dept. Exh. 11.

With Regard to the First and Fourth Counts

12. The nursing home administrator is responsible for the overall management of the nursing home. Tr. 8/13/98, pp. 141-142; Tr. 9/25/98, pp. 15-16.
13. During the visits conducted at Barnett between July 17 and July 30, 1996, respondent was unable to provide the Department assurances that sufficient staffing would be available to ensure the residents received quality of care. Dept. Exh. 8, pp. 62-63; Tr. 8/13/98, pp. 118-119.
14. During the period of July 18 through 23, 1996, five residents with a history of a significant weight loss failed to receive Magnacal, a nutritional supplement, as per physician's orders, due to the supplement not being available in the facility. Dept. Exh. 9, pp. 6-9.
15. On July 19, 1996, four residents with a history of a significant weight loss and/or with pressure sore development failed to receive Promod, a protein supplement, as per physician orders, due to the supplement not being available in the facility. Dept. Exh. 9, pp. 10, 15, and 16; Tr. 8/13/98, p. 120.
16. A pressure sore is a breakdown of the skin, which is categorized in four stages: a stage I is a reddening of the area, a stage II is a superficial break of the skin, a stage III is a deep erosion of the skin extending to the muscle, and a stage IV is an erosion of the skin extending to the bone. Tr. 9/24/98, p.29.
17. On July 29, 1996, one resident, with a pressure sore failed to receive a treatment of Zeasorb-AF powder, as per physician orders, due to the medication not being available in the facility. Dept. Exh. 9, p. 21; Tr. 8/13/98, p. 120; Tr. 9/24/98, pp. 68-70.
18. On July 20, 1996, two residents with Stage II sores had not been provided with pressure relieving devices on their beds due to none being available in the facility. Dept. Exh. 9, pp. 19 and, 22; Tr. 8/13/98, pp. 56 and 120.
19. On July 20, 1996, residents who were incontinent of urine had not been provided with incontinent care three times a shift due to the facility not having sufficient linen. Dept. Exh. 9, p. 23; Tr. 8/13/98, p. 120.
20. During the visits conducted at Barnett between July 17 and July 30, 1996, respondent was unable to provide the Department with assurances that he could ensure the financial viability of the facility. Tr. 8/13/98, pp. 121-125.

21. Violations relative to patient care identified during the visits conducted between July 17 and July 30, 1996, revealed that an emergency situation existed at Barnett which jeopardized the health, safety and welfare of the residents. Tr. 8/13/98, p. 150.
22. During the visits conducted at Barnett between July 17 and July 30, 1996, the inspectors found that the facility had provided substandard quality of care which constituted immediate jeopardy to the health and safety of the residents at the facility. Dept. Exh. 8, p. 1; Tr. 8/13/98, pp. 116-118.

With Regard to the Second Count

23. The nursing home administrator's responsibility includes serving as a liaison between the governing body, medical and nursing and other professionals and supervisory staff. Tr. 8/13/98, pp. Tr. 9/25/98, pp. 17-18.
24. During the period of April through July of 1996, there were no quality assurance meetings conducted on a monthly basis as provided for in the facility policy. Dept. Exh. 4; Dept. Exh. 8, pp. 71-72; Dept. Exh. 9, pp. 31-32; Tr. 8/13/98, pp. 131-132.
25. During the period of April through July of 1996, respondent failed to implement a quality assurance plan as required by the facility protocol, to identify and/or resolve problems in the facility. Dept. Exh. 8, pp. 71-73; Tr. 8/13/98, pp. 132-133.
26. A survey conducted by the Department at Barnett in April of 1996, identified pressure sores on residents as a problem. Tr. 8/13/98, p. 51.
27. The inspection conducted on July 17, 1998, identified a significant increase in the pressure sore rate on residents since the April survey. These findings were reported to respondent. Tr. 8/13/98, pp. 53, 65, and 133.
28. An inspection conducted on July 21, 1998, found that Barnett had not conducted an assessment of the pressure sores in the resident population since the July 17th inspection. Tr. 8/13/98, p. 69.
29. On July 21, 1996, the inspectors met with respondent and explained to him that the Department considered the conditions of Barnett to be substandard. Respondent advised the inspectors that he had no concerns regarding the operation of the facility. Tr. 8/13/98, p. 65.

30. An inspection conducted on July 22, 1996, identified still more pressure sores on residents. Tr. 8/13/98, p. 69.
31. Respondent failed to identify or address the increase in pressure sores, from April through July 23, 1996. Dept. Exh. 8, p. 29; Tr. 8/13/98, p. 134.
32. Even after being advised of the gravity of the situation, Barnett failed to present a plan for addressing the pressure sore problem, and inspectors were required to assess the residents for pressure sores themselves. Tr. 8/13/98, p. 70.
33. Between July 17 and 30, 1996, respondent failed to identify the problem of not having sufficient linens to meet the needs of the residents and/or the minimum requirements of the Connecticut Public Health Code. Dept. Exh. 9, p. 23; Tr. 8/13/98, p. 134.
34. Respondent failed to ensure that an intravenous therapy committee had been established as per facility protocol. Although Barnett's policy directed that IV data be reviewed monthly, in July of 1996, the Department inspectors found that a review of the facility's intravenous therapy program had not occurred since April of 1996. Dept. Exh. 9, p. 32; Dept. Exh. 12; Tr. 8/13/98, pp. 135-136 and 140.
35. Between July 17 and July 30, 1996, seven residents with identified infections were not appropriately monitored, as required by the infection control policies of Barnett. Dept. Exh. 8, pp. 63-69; Tr. 9/24/98, pp. 59-60.
36. During March through July of 1996, the infection control policies of Barnett had not been implemented. Dept. Exh. 20; Dept. Exh. 9, pp. 34-35; Tr. 9/24/98, pp. 52-53 and 60.
37. During March through July of 1996, the infection control committee at Barnett failed to direct the facility's response to infection and failed to identify corrective measures. Dept. Exh. 9, p. 34; Tr. 9/24/98, p. 60.
38. During March through July of 1996, Barnett failed to implement infection control policies relative to its intravenous therapy program. Dept. Exh. 9, p. 34; Tr. 9/24/98, pp. 60-61.

With Regard to the Third Count

39. During the period of April of 1996 through and including August of 1996, respondent failed to enforce all applicable local and state regulations as well as facility by-laws. Tr. 8/13/98, pp. 142-143, 148, and 149.
40. During the visits at Barnett conducted between July 17 and 30, 1996, the inspectors discovered numerous violations of the Connecticut Public Health Code, Connecticut General Statutes. Tr. 8/13/98, pp. 142-149.
41. During the visits at Barnett conducted between July 17 and 30, 1996, respondent failed to ensure that nineteen of twenty-three sampled residents with pressure sores received necessary treatments and/or services and/or skin assessments to promote healing, prevent infection and prevent additional sores from developing. This was a violation of Public Health Code §§19-13-D8t(m)(2) and/or (t)(2)(A). Dept. Exh. 9, pp. 14-25; Tr. 9/25/98, p. 112.
42. During the period of April of 1996 through and including July of 1996, respondent failed to ensure that the only patient receiving intravenous therapy received proper treatment and care. This was a violation of Public Health Code §§19-13-D8t(m)(2) and/or 19-13-D8u(c); Dept. Exh. 9, pp. 30-31; Tr. 9/25/98, p. 112.
43. During the period of April of 1996 through and including July of 1996, Barnett's Quality Assessment and Assurance Committee failed to meet at least quarterly to identify issues, and develop and implement appropriate plans of action to correct identified quality deficiencies. This was a violation of Public Health Code §§19-13-D8t(e)(1)(B) and/or (e)(2)(C) and/or (f)(3); Dept. Exh. 9, pp. 31-32; Tr. 9/25/98, p. 112.
44. During the period of April of 1996 through and including July of 1996, respondent failed to maintain an infection control program designed to provide an environment that prevents the development and transmission of infection. This was a violation of Public Health Code §§19-13-D8t(t)(2)(A) and/or (t)(2)(B) and/or (t)(3) and/or (m)(2)(C); Dept. Exh. 9, pp. 32-35; Tr. 9/25/98, p. 112.

Discussion and Conclusions of Law

Section 19a-517 of the Connecticut General Statutes provides, in pertinent part, as follows:

- (a) The Department of Public Health shall have jurisdiction to hear all charges of unacceptable conduct brought against any person licensed to practice as a nursing home administrator
- (b) The Department may take action under section 19a-17 for any of the following reasons:

. . . (3) illegal, incompetent, or negligent conduct in his practice; or
(4) violation of any provision of this chapter or any regulation adopted
hereunder. . . .

Section 19-13-D8t(f)(3) of the Regulations provides, in pertinent part, as follows:

The administrator shall be responsible for the overall management of the facility and shall have the following powers and responsibilities: (A) enforcement of any applicable local and state regulations, and federal regulations that may apply to federal programs in which the facility participates, and facility by-laws; (B) appointment, with the approval of the governing body, of a qualified medical director and the director of nurses and, if necessary, an assistant director of nurses; (C) liaison between the governing body, medical and nursing staff, and other professional and supervisory staff; . . . (F) with the advice of the medical director and director of nurses, employment of qualified personnel in sufficient numbers to assess and meet residents needs

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Swiller v. Commissioner of Public Health*, No. CV 95-0705601 (Sup. Court, J.D. Hartford/New Britain at Hartford, October 10, 1995).

Respondent does not contest the Department's findings made during the July 1996 inspections of Barnett, but argues that he should not be found negligent under §19a-517 of the Connecticut General Statutes for the following two reasons:

1. *The Department has failed to establish the four elements of a negligence cause of action: a duty, breach of the duty, causation, and damage.*

Although respondent claims that the appropriate standard that he should be judged by under §19a-517(b)(3) of the Connecticut General Statutes is the standard for a civil negligence cause of action, he provides no case or statutory authority to support this claim. In the construction of statutes, words and phrases are construed according to the commonly approved usage of the language. Connecticut General Statutes §1-1(a). The term "negligence" is defined as "[t]he omission or neglect of reasonable precaution, care, or action." *The American Heritage Dictionary: 2nd College Edition* at 835 (1985). The

definition of “conduct” includes “[t]he way a person acts; behavior.” *Id* at 307.

Negligent conduct under §19a-517(b)(3) of the Connecticut General Statutes is, therefore, the acts or behavior of a nursing home administrator which demonstrate the omission or neglect of reasonable precaution or care. The record reveals overwhelming evidence of such negligent conduct on respondent’s part.

2. *While employed at Barnett, respondent was in a probationary status and did not have the authority to act as the nursing home administrator.*

Respondent represented on numerous occasions, including by the submission of an Administrator’s Affidavit, that he was Barnett’s nursing home administrator. The record does not establish that he was in a probationary status. Further, appellant presented no case or statutory authority that would authorize a nursing home administrator to not comply with the Public Health Code because of a probationary status.

With regard to the First Count, the Department sustained its burden of proof. The evidence establishes that respondent failed in his duties to be responsible for the overall management and operation of Barnett in violation of §19a-517(b)(3) and (4) of the Connecticut General Statutes.

With regard to the Second Count, the Department sustained its burden of proof. The evidence establishes that respondent failed in his duties to serve as a liaison between the governing body, medical and nursing staff and other professionals and supervisory staff in violation of §19a-517(b)(3) and (4) of the Connecticut General Statutes.

With regard to the Third Count, the Department sustained its burden of proof. The evidence establishes that respondent failed to enforce all applicable state regulations as well as the Barnett bylaws in violation of §19a-517(b)(3) and (4) of the Connecticut General Statutes.

With regard to the Fourth Count, the Department sustained its burden of proof. The evidence establishes that respondent failed to ensure that sufficient numbers of

qualified personnel were employed to ensure that patient needs were assessed in violation of §19a-517(b)(3) and (4) of the Connecticut General Statutes.

Respondent's many violations of state regulations and Barnett bylaws, and his repeated failure to conform to the minimum requirements of a nursing home administrator, demonstrate a significant breach of the standard of care for nursing home administrators. The very fact that respondent claims that he was not responsible because he was on probation makes it clear that he does not understand the role of an administrator in a nursing home. The conduct as demonstrated by respondent warrants the revocation of his nursing home administrator's license.

Order

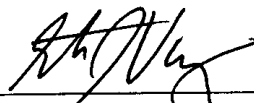
Based on the record in this case, the above findings of fact and conclusions of law, this Hearing Officer orders the following in this case against Maurice Henowitz, Petition No. 960813-036-002, nursing home administrator's license No. 1300:

Respondent's license to practice as a nursing home administrator is revoked. Respondent shall send all copies of his license to:

Bonnie Pinkerton
Department of Public Health
410 Capitol Avenue MS# 12 LEG
P.O. Box 340308
Hartford, CT 06134-0308

2/4/99

Date



Stephen J. Varga
Hearing Officer